

Navigating Ethical Tensions in Primary Healthcare Nursing: Frequency, Impact, and Management Strategies in Ethical Dilemmas

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<https://doi.org/10.82086/hjn.v65i2.865>

Διαχείριση Ηθικών Εντάσεων στη Νοσηλευτική Πρωτοβάθμιας Φροντίδας Υγείας: Συχνότητα, Αντίκτυπος και Στρατηγικές Αντιμετώπισης Ηθικών Διλημμάτων

Abstract at the end of the article

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Υποβλήθηκε: 18/11/2025
Επανυποβλήθηκε: 10/02/2026
Εγκρίθηκε: 24/04/2026

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Background: Ethical decision-making is central to nursing practice, yet the frequency and nature of ethical dilemmas in primary healthcare settings remain underexplored. Nurses often operate autonomously in resource-limited environments, where institutional support and formal ethics infrastructures are scarce.

This study aimed to investigate the frequency, perceived impact, and management strategies of ethical dilemmas among primary healthcare nurses in Greece, as well as the demographic and professional predictors of ethical attitudes and knowledge.

Material and Methods: A cross-sectional descriptive-analytical study was conducted among 492 registered nurses working in public primary healthcare units under the 2nd Regional Health Authority of Piraeus and the Aegean. Data were collected using a structured questionnaire including demographic variables and the Nurses' Ethics Questionnaire (NEQ-Gr). Descriptive statistics, bivariate analyses, and multiple linear regressions were performed using IBM SPSS Statistics 28.0.

Results: Ethical dilemmas were frequent, with 73% of nurses encountering them at least monthly. Moral distress—acting against personal ethical values—was reported by 47% at least occasionally. The overall ethical attitude score was high (mean 3.8 ± 0.4), reflecting positive orientations toward truth-telling, informed consent, and patient autonomy. Higher education ($b = 0.03$, $p = 0.048$) and employment in areas with refugee reception facilities ($b = 0.18$, $p < 0.001$) predicted stronger ethical attitudes. Educational level was the only significant predictor of ethical knowledge ($b = 0.10$, $p = 0.014$).

Conclusions: Greek primary healthcare nurses frequently face ethically challenging situations with limited institutional support. Education and

work context significantly influence ethical competence. Establishing ethics committees, integrating applied ethics into nursing curricula, and fostering moral resilience are essential to strengthen ethical decision-making and the moral integrity of care.

Keywords: *Nursing ethics; Ethical dilemmas; Primary healthcare; Moral distress; Ethical knowledge; Ethical attitudes; Ethics committees;*

Introduction

The delivery of ethical care is a cornerstone of professional nursing practice. In the context of primary healthcare, where nurses operate with high autonomy and in close proximity to patients and communities, ethical decision-making is frequently challenged by conflicting duties, limited resources, cultural diversity, external and systemic constraints.¹⁻⁵ Despite the growing academic emphasis on bioethics in nursing education, the everyday ethical realities faced by nurses in primary care remain underexplored.

Ethical dilemmas in nursing span a wide spectrum, from truth-telling and informed consent to end-of-life decision-making, professional boundaries, and conflicts of interest.⁶ In particular, the principle of moral agency — the ability to act in accordance with ethical principles despite external pressure — is often compromised by institutional demands and cultural expectations.⁷⁻⁹ The phenomenon of moral distress, where nurses recognize the ethically appropriate action but feel powerless to act, has been extensively reported in hospital settings¹⁰⁻¹², but less so in primary care environments.

In multicultural and ethically demanding settings, such as those involving migrant or refugee populations, ethical conflicts can intensify. Research suggests that these environments challenge nurses to navigate between respecting cultural norms and adhering to ethical-legal standards of care.³ The need for context-sensitive ethics training and institutional support structures, including Ethics Committees, is widely recognized in international guidelines¹³⁻¹⁵, yet their implementation remains uneven. Moreover, Fradelos et al. underscore the vital role of ethical environments in shaping not only the professional lives of nurses but also the quality of care provided to patients, thus highlighting the interconnectedness of ethical practice and healthcare outcomes.¹⁶

Ethical dilemmas in primary healthcare in Greece are prominently influenced by limited resources, organizational constraints, and cultural diversity. Nurses often

experience moral distress when they encounter situations where they cannot uphold ethical principles due to systemic barriers, which negatively impacts their job satisfaction and emotional well-being.¹⁷ Few studies have systematically explored how often nurses face ethical conflicts in these settings, how such experiences influence their moral confidence, and how ethical decision-making is managed in the absence of formal ethics infrastructures.

This study responds to that gap by analyzing data from a cross-sectional survey of 492 nurses working in public primary healthcare settings in Greece. Drawing on previously underexamined variables, it focuses on:

- The frequency and impact of ethical dilemmas;
- The professional and emotional burden of acting against one's ethical judgment;
- Nurses' strategies for resolving ethical conflicts;
- The availability and perception of ethics support systems (e.g., institutional Ethics Committees).

By understanding how ethical tensions manifest and are managed in real-world primary care settings, this research aims to inform policy, training, and institutional frameworks that better support ethical nursing practice.

Methods

Study Design and Setting

This study employed a cross-sectional descriptive-analytical design to explore the frequency, impact, and management strategies of ethical dilemmas among nurses working in public primary healthcare settings in Greece. The study setting was the jurisdiction of the 2nd Regional Health Authority of Piraeus and the Aegean, a region characterized by cultural diversity and the presence of migrant and refugee reception centers. Primary healthcare units in this area serve as frontline facilities, providing preventive, diagnostic, and community-based care.

Participants and Sampling

The target population comprised all registered nurs-

Table 1. Demographic and professional characteristics of participants (N = 492).

Variable	n (%)	Mean (SD)
Gender	Male 55 (11.3%) Female 433 (88.7%)	
Age (years)		42.2 (9.7)
Marital status	Single 127 (25.9%) Married 293 (59.8%) Civil partnership 25 (5.1%) Divorced 39 (8.0%) Widowed 6 (1.2%)	
Education	Two-year 110 (22.4%) TEI 199 (40.4%) AEI 50 (10.2%) MSc 129 (26.2%) PhD 4 (0.8%)	
Work unit	Mainland 313 (63.6%) Island 179 (36.4%)	
Years of experience		16.0 (9.9)
Work near migrant/refugee facility	Yes 89 (18.1%) No 403 (81.9%)	

es employed in public primary healthcare units under the authority of the 2nd Regional Health Authority at the time of data collection. A census approach was employed, surveying the entire target population, to ensure a comprehensive representation of the professional experiences, cultural interactions, and ethical perspectives within the healthcare setting.

Inclusion criteria were:

- currently practicing as a registered nurse,
- at least one year of professional nursing experience,
- direct patient care responsibilities.

Exclusion criteria were:

- managerial/administrative positions without direct clinical contact,
- student nurses,
- healthcare professionals employed outside the public primary healthcare system.

Out of 737 questionnaires distributed, 492 were completed and returned (response rate: 67%), ensuring a robust dataset representative of the regional nursing workforce.

Instruments

Data were collected using a composite, self-administered questionnaire designed to capture demographic, professional, and ethical dimensions of nursing practice. The instrument comprised two primary components: a demographic and professional profile section, and the Nurses' Ethics Questionnaire (NEQ-Gr)¹⁸, which measured nurses' ethical knowledge, attitudes, and practices.

The demographic section gathered information on

participants' socio-demographic and occupational characteristics relevant to the interpretation of ethical attitudes and behaviors. Specifically, it included questions on gender, age, marital status, educational attainment, years of professional experience, and workplace location (mainland or island-based healthcare unit). Participants were also asked to indicate whether their workplace was located in a region hosting a refugee reception or closed-controlled facility under the jurisdiction of the Ministry of Migration and Asylum. These variables were selected based on prior evidence linking educational level, professional experience, and exposure to multicultural patient populations with ethical sensitivity and decision-making in nursing.

The second part of the questionnaire employed the Nurses' Ethics Questionnaire (NEQ-Gr), which was used to measure nurses' knowledge, attitudes, and practices concerning healthcare ethics. The original instrument, developed and validated by Hariharan et al.¹⁹ is a 28-item tool that has been cross-culturally adapted and psychometrically tested in Greek nursing populations. The NEQ-Gr is divided into two main sections designed to capture different facets of ethical competence and behavior in nursing practice.

The first section, consisting of 13 items, evaluates the perceived frequency and clinical impact of common ethical and legal dilemmas encountered in everyday nursing practice. It also explores the perceived importance of ethical and legal knowledge in clinical decision-making and identifies nurses' preferred sources of ethical information, such as formal education, professional experience, self-directed learning, and participation in lectures or seminars. In addition, this section investigates the professional consultation pathways nurses choose

Table 2. Frequency and impact of ethical dilemmas in clinical practice (N = 492).

Ethical Dilemma Variable	Category/ n (%)
Frequency of encountering ethical/legal problem	Never 28 (5.7%) Daily 57 (11.6%) Weekly 142 (28.9%) Monthly 163 (33.1%) Yearly 102 (20.7%)
Ethical problems hinder practice	None 40 (8.1%) Slight 184 (37.4%) Moderate 206 (41.9%) Severe 39 (7.9%) Very severe 23 (4.7%)
Forced to act against ethical/legal views	Never 75 (15.2%) Rarely 183 (37.2%) Sometimes 161 (32.7%) Often 55 (11.2%) Very often 18 (3.7%)
Conflict with colleagues over ethics	Never 8 (1.6%) Rarely 211 (42.9%) Sometimes 210 (42.7%) Often 51 (10.4%) Very often 12 (2.4%)

Table 3. Bivariate associations between demographic variables and ethical attitudes and knowledge.

Variable	Ethical Attitudes (Mean ± SD)	p-value	Ethical Knowledge (Mean ± SD)	p-value
Gender	M: 3.7 ± 0.4 / F: 3.8 ± 0.4	0.45	M: 2.4 ± 0.9 / F: 2.4 ± 0.9	0.85
Age (years)	r = -0.08	0.07	r = -0.05	0.29
Education level	ρ = 0.08	0.09	ρ = 0.11	0.01*
Experience (years)	ρ = -0.07	0.11	ρ = -0.007	0.86
Work unit	Mainland: 3.7 / Island: 3.8	0.02	Mainland: 2.3 / Island: 2.4	0.69
Refugee facility nearby	Yes: 3.9 / No: 3.7	<0.001**	Yes: 2.2 / No: 2.4	0.14

*Significant at p < 0.05; **Significant at p < 0.001.

when faced with ethical or legal challenges, including peers, supervisors, and institutional support mechanisms. Items in this section employ a combination of binary (Yes/No) and Likert-type scales, allowing for both categorical and ordinal analysis of responses.

The second section of the NEQ-Gr, which includes 15 items, focuses on nurses' ethical attitudes and responses to common moral and bioethical dilemmas encountered in clinical practice. Using a five-point Likert scale (1 = strongly disagree to 5 = strongly agree), participants express their degree of agreement with statements reflecting ethical principles such as respect for autonomy, beneficence, non-maleficence, justice, and confidentiality. This section provides a comprehensive assessment of nurses' moral awareness and reasoning in the face of real-world ethical challenges, such as end-of-life care, informed consent, and patient advocacy.

In the present study, the internal consistency reliability of the 10-item ethical attitudes subscale of the NEQ-Gr (Cronbach's alpha), was 0.65, which indicates acceptable reliability for complex psychosocial constructs such as ethical reasoning. In interpreting the results, descriptive categories were employed to facilitate the comparison of findings. Mean item scores between 3.5 and 5.0 were considered indicative of positive ethical attitudes, consistent with previous studies utilizing the NEQ in nursing

research. Although no standardized cut-off values exist for this instrument, these interpretive ranges align with prior methodological literature assessing ethical competence in healthcare professionals.

Permission to use both the Greek version of the Nurses' Ethics Questionnaire (NEQ-Gr) and the original English version was formally obtained from the respective instrument developers prior to data collection.

Data Collection Procedure

Data collection occurred between February and May 2024. Questionnaires were distributed in sealed envelopes accompanied by an information sheet and consent form. Participation was voluntary, and anonymity was guaranteed. Returning a completed questionnaire was considered implied informed consent. Two reminder notifications were issued during the collection period to optimize participation rates.

Statistical Analysis

Data analysis was conducted using IBM SPSS Statistics, version 28.0. Categorical variables were summarized as absolute and relative frequencies, whereas continuous variables were presented as mean, standard deviation, median, minimum, and maximum values. The Kolmogorov-Smirnov test was employed to examine the normal-

Table 4. Multiple linear regression predicting ethical attitudes.

Predictor	b	95% CI for b	p-value
Education level	0.03	0.001 – 0.07	0.048*
Work near refugee facility	0.18	0.09 – 0.28	<0.001**

*Significant at $p < 0.05$; **Significant at $p < 0.001$.

Table 5. Multiple linear regression predicting ethical knowledge.

Predictor	b	95% CI for b	p-value
Education level	0.10	0.02 – 0.17	0.014*

*Significant at $p < 0.05$.

ity of distribution for quantitative variables. Depending on the level of measurement and distribution, appropriate statistical tests were applied: independent-samples t-tests, one-way analysis of variance (ANOVA), Pearson's correlation coefficient, or Spearman's correlation coefficient.

To further investigate associations and control for potential confounding, multivariable linear regression analyses were performed. Dimensions of ethical outcomes were entered as dependent variables, while demographic and professional characteristics served as independent predictors. Variables with a bivariate significance of $p < 0.20$ were included in the multivariable models, using the likelihood-ratio method with entry and removal limits set at $p < 0.05$ and $p > 0.10$, respectively. Regression coefficients (b), 95% confidence intervals, and corresponding p-values are reported for statistically significant predictors. Statistical significance was defined at the two-tailed level of $p < 0.05$.

Ethical Considerations

The study was approved by the Research Ethics and Deontology Committee of the University of Peloponnese and by the Scientific Council of the 2nd Regional Health Authority of Piraeus and the Aegean. Participation was voluntary, with guarantees of anonymity, confidentiality, and the right to withdraw at any point.

Results

Participant Characteristics

A total of 492 registered nurses working in public primary healthcare units across mainland and insular Greece participated in the study. The mean age of respondents was 42.2 years ($SD = 9.7$, range = 20–66), and the median age was 42 years. The majority were female

(88.7%), and most were married or in a civil partnership (64.9%).

Regarding educational background, 77.6% were graduates of a Technological Educational Institute (TEI) or University (AEI), 22.4% had completed a two-year nursing program, 26.2% held a postgraduate (MSc) degree, and 0.8% held a doctoral (PhD) degree.

Most nurses worked in mainland units (63.6%), while 36.4% were employed in island-based healthcare facilities. Eighteen percent (18.1%) worked in areas with a Refugee Reception or Closed-Controlled Structure under the Ministry of Migration and Asylum.

The mean years of professional experience was 16 years ($SD = 9.9$; median = 15), ranging from 8 months to 40 years. These demographic and professional characteristics are summarized in Table 1.

Frequency and Impact of Ethical Dilemmas

Ethical and legal dilemmas were reported to be a common feature of daily nursing practice. Only 5.7% of participants stated they never encountered such dilemmas, whereas 11.6% reported facing them daily, 28.9% weekly, and 33.1% monthly. The remaining 20.7% experienced them less than once per year (Table 2).

Perceived impact on clinical practice varied: 41.9% reported that ethical problems considerably hindered their daily practice, 37.4% said they posed minor difficulties, and 8.1% reported no impact.

Moral distress was also evident: 37.2% of nurses reported that they were "rarely" required to act against their ethical or legal beliefs, 32.7% "sometimes," 11.2% "often," and 3.7% "very often," while 15.2% indicated "never."

Interpersonal ethical conflict was common. Nearly 43% of nurses reported experiencing such conflict "rare-

ly," 42.7% "sometimes," and 10.4% "often," whereas only 1.6% said "never" and 2.4% "very often."

These results highlight that ethical tensions are pervasive in Greek primary healthcare, often producing professional discomfort and interpersonal friction.

Ethical Knowledge and Information Sources

Knowledge of professional laws and ethical frameworks was moderate overall. Nearly half of respondents (47.2%) reported knowing "most" of the laws relevant to their duties, while 34.1% knew "a few," and 2.2% admitted to knowing none. Almost all participants (81.5%) considered ethical knowledge "very important" to their work.

Knowledge was primarily obtained through work experience (74.2%) and formal education (72.2%), while 38.8% cited personal study and 29.5% cited seminars or lectures.

Regarding familiarity with major ethical frameworks, 92.9% knew the Hippocratic Oath, 81.9% the Nursing Code of Ethics, 32.5% the Nuremberg Code, and 28.9% the Declaration of Helsinki.

Participants rated lectures (96.5%), conferences (95.9%), and books (92.7%) as the most useful sources of ethical knowledge. The mean composite ethical knowledge score was 2.4 ± 0.9 (range 0–4), indicating moderate awareness of key ethical principles.

Consultation and Institutional Ethics Support

When confronted with ethical dilemmas, nurses most frequently sought advice from colleagues (72.8%) and supervisors (67.3%). Consultation with a Director of Nursing Services (35%) and family or friends (24.6%) was also common.

In cases involving legal issues, lawyers (70.1%) and supervisors (52.2%) were the most consulted resources, followed by colleagues (44.7%).

A substantial majority (72.8%) of participants believed that their workplace should have an Ethics Committee. The most frequently endorsed roles of such committees were:

- Advising staff on ethical/legal issues (88.6%),
- Ensuring ethical and deontological standards (84.1%), and
- Advising management on institutional ethics and policies (71.7%).

Approximately half of respondents also supported ad-

ditional functions, such as conflict resolution between professionals and families (46.7%) and teaching medical ethics to students (43.1%).

These findings indicate both a reliance on informal ethical support networks and a strong perceived need for structured institutional ethics mechanisms.

Ethical Attitudes and Bioethical Perspectives

The internal consistency of the ethical attitudes scale was acceptable (Cronbach's $\alpha = 0.650$). The mean attitude score was 3.8 ± 0.4 (range 2.5–5.0), suggesting generally positive ethical orientations among participants.

Most nurses strongly supported patient autonomy and transparency. Specifically, 79.5% agreed that patients should always be informed of medical errors, 75.6% believed that patients should actively participate in decision-making, and 73.2% agreed that full disclosure should be provided even in severe illness.

Fewer nurses endorsed statements limiting patient rights. Only 10.8% agreed that ethical behavior is important solely to avoid legal consequences, and 10.0% agreed that patient consent is required only for surgical procedures.

Regarding bioethical dilemmas, 63.0% disagreed that a patient requesting death should be assisted regardless of illness, while 80.7% believed healthcare professionals should advise rather than simply respect a patient's decision when refusing treatment. Opinions were divided on abortion: 46.5% agreed that nurses cannot refuse participation when legally permitted, 25.0% disagreed, and 28.5% were unsure.

Almost all participants (79.9%) agreed that children should not receive treatment without parental consent (except in emergencies). A majority (54.2%) disagreed with automatic organ donation without family consent.

These patterns indicate a strong commitment to patient rights and professional accountability, but also ethical ambivalence in morally sensitive domains such as end-of-life care and abortion.

Summary of Descriptive Findings

The analysis revealed that ethical dilemmas are frequent and multifaceted in primary healthcare nursing. Moral distress, limited institutional ethics infrastructure, and dependence on informal consultation networks were recurrent themes. Despite moderate knowledge levels, nurses displayed high ethical awareness and strong endorsement of patient autonomy. Education and work context (particularly in multicultural or

high-pressure environments) likely shape ethical confidence and behavior—an issue to be explored further in the discussion.

Correlations Between Ethical Dimensions and Demographic Variables

Bivariate analyses explored relationships between nurses' ethical attitudes, ethical knowledge, and selected demographic and professional characteristics (Table 3).

No statistically significant correlations were observed between ethical attitudes and age ($r = -0.08$, $p = 0.07$), years of experience ($r = -0.07$, $p = 0.11$), or educational level (Spearman's $\rho = 0.08$, $p = 0.09$). Likewise, gender ($p = 0.45$), marital status ($p = 0.16$), and work setting (mainland vs. island; $p = 0.02$, non-significant after correction) were not associated with significant differences in mean ethical attitude scores.

However, a significant positive association was identified between working in a healthcare unit located near a refugee reception or closed-controlled facility and more positive ethical attitudes ($p < 0.001$). Nurses serving in such areas scored on average 3.9 (SD = 0.5) compared to 3.7 (SD = 0.4) for those in other regions.

Regarding ethical knowledge, there were no significant associations with gender ($p = 0.85$), age ($p = 0.29$), or years of experience ($p = 0.86$). Yet, educational level showed a positive correlation with knowledge scores ($p = 0.11$, $p = 0.01$), indicating that nurses with higher education levels demonstrated greater awareness of ethical principles.

A marginal trend suggested that nurses working near migrant or refugee facilities exhibited slightly lower mean knowledge scores (2.2 ± 1.0) compared to those elsewhere (2.4 ± 1.0), although this did not reach conventional significance ($p = 0.14$).

Predictors of Ethical Attitudes and Knowledge

Variables with $p < 0.20$ in the bivariate analyses were entered into multivariable linear regression models to identify independent predictors of ethical attitudes and ethical knowledge (Tables 4 and 5).

Predictors of Ethical Attitudes

In the final regression model, two variables remained statistically significant.

- Educational level was a positive predictor ($b = 0.03$, 95% CI [0.001–0.07], $p = 0.048$).

- Working in areas with a refugee or closed-controlled facility was also associated with significantly higher ethical attitude scores ($b = 0.18$, 95% CI [0.09–0.28], $p < 0.001$).

These predictors explained 2.9% of the variance in ethical attitudes (Adjusted $R^2 = 0.029$).

These findings indicate that nurses with higher educational attainment and those working in multicultural or ethically complex contexts display stronger ethical awareness and more positive ethical orientations.

Predictors of Ethical Knowledge

Only educational level emerged as a significant predictor of ethical knowledge ($b = 0.10$, 95% CI [0.02–0.17], $p = 0.014$), explaining approximately 1% of the variance in knowledge scores (Adjusted $R^2 = 0.010$).

This finding underscores the role of formal education in fostering ethical literacy and supports the integration of structured ethics education in both undergraduate and continuing nursing curricula.

Summary of Inferential Findings

The regression models demonstrate that while nurses' ethical knowledge and attitudes are generally high, they are modestly influenced by education and workplace context. Specifically:

- Higher education corresponds to stronger ethical knowledge and attitudes.
- Working in multicultural, high-ethics-demand environments (such as refugee or controlled-facility areas) enhances moral sensitivity and ethical responsiveness. These findings suggest that contextual exposure and educational empowerment are critical drivers of ethical development in primary healthcare nursing.

Discussion

This study examined the frequency, nature, and management of ethical dilemmas among nurses working in primary healthcare settings in Greece and explored the demographic and contextual predictors of ethical attitudes and knowledge. The findings revealed that ethical challenges are pervasive, frequently encountered, and often associated with emotional and professional strain. Despite moderate levels of ethical knowledge, participants displayed overall positive ethical orientations and a strong sense of professional responsibility toward patient autonomy and transparency.

The vast majority of nurses reported facing ethical or legal dilemmas at least monthly, and one in ten

faced them daily. These rates indicate that ethical decision-making is not an exceptional event in primary care but rather a routine and integral part of nursing practice. Similar findings have been reported in hospital-based studies²⁰, but fewer data have been available for community and primary care contexts. The frequent exposure to ethical tensions may reflect the decentralized, multi-role character of primary healthcare in Greece, where nurses must make autonomous decisions often without immediate support from colleagues of the same or other disciplines.

The perception that ethical problems significantly hinder clinical work is consistent with the concept of moral distress, as defined by Jameton²¹ and further developed by Hamric and Epstein²². Moral distress arises when nurses recognize the ethically appropriate action but are constrained from acting due to institutional or hierarchical barriers. The fact that nearly half of respondents reported being compelled to act against their ethical or legal beliefs at least occasionally suggests a persistent gap between ethical intent and operational capacity. This finding underscores the need for institutional mechanisms that enable nurses to express and resolve moral concerns safely. The research suggests that implementing supportive frameworks, such as nursing ethics huddles and moral empowerment programs, can help nurses cope with morally distressing situations by fostering open discussions about their ethical concerns²³.

The overall level of ethical knowledge among participants was moderate, with greater familiarity observed for the Hippocratic Oath and the Nursing Code of Ethics than for international frameworks such as the Nuremberg Code or the Declaration of Helsinki. This pattern suggests that nursing ethics education in Greece remains predominantly focused on professional deontology rather than on universal bioethical principles. Comparable trends have been identified in other European countries, where curricular emphasis often prioritizes legal compliance over moral reasoning²⁴.

Consistent with the literature, education and work experience were the main reported sources of ethical knowledge^{25,26}. However, the regression analysis demonstrated that formal education—not experience—was the only significant predictor of higher ethical knowledge. This finding aligns with research emphasizing that ethics knowledge is acquired most effectively through structured academic programs, reflective discussion, and case-based learning²⁷. It also highlights the need for continuous professional development and lifelong

learning initiatives focusing on applied ethics in primary care.

Participants expressed consistently positive ethical attitudes, especially regarding truth-telling, informed consent, and patient participation in decision-making. These findings reflect a strong endorsement of patient autonomy, which is central to contemporary nursing ethics²⁸. Notably, moral reasoning was more context-sensitive in areas such as abortion, euthanasia, and organ donation—issues that often elicit moral ambivalence due to cultural and religious factors^{29,30}.

Regression analyses identified educational level and work in regions with refugee or closed-controlled facilities as significant predictors of stronger ethical attitudes. The first finding reinforces the established link between academic preparation and ethical discernment³¹. The second suggests that exposure to multi-cultural or ethically complex environments enhances nurses' ethical awareness and sensitivity. Working with refugee and migrant populations often confronts nurses with conflicting moral norms, communication barriers, and systemic inequities, requiring active ethical reflection and value negotiation. Similar evidence from cross-cultural nursing studies indicates that moral reasoning develops through experience in ethically challenging contexts^{3,32}.

Most nurses relied on colleagues and supervisors for advice on ethical dilemmas, reflecting the informal nature of moral deliberation in primary healthcare. The absence of structured institutional ethics support was striking: although nearly three-quarters of respondents believed that an Ethics Committee should exist, few reported access to one. This mirrors global findings showing that healthcare professionals often lack formal ethical consultation services in community settings³³.

Institutional Ethics Committees are known to play a key role in promoting ethical climate, preventing moral distress, and enhancing moral resilience³⁴. Establishing such committees in primary healthcare could provide a structured forum for discussion, guidance, and education, bridging the gap between ethical awareness and organizational support.

The observed moral distress among participants—manifested as acting against personal ethical values—underscores the ethical vulnerability of nurses working in resource-constrained environments. Greek primary care has long suffered from limited staffing, administrative overload, and insufficient ethics infrastructure, especially after the economic crisis^{35,36}. In such contexts,

nurses may experience ethical dissonance between professional ideals and institutional realities. Research reveals that moral distress can lead to burnout, reduced job satisfaction, and emotional withdrawal, ultimately compromising care quality³⁷.

The finding that nurses in refugee reception areas showed more positive ethical attitudes, despite working in demanding conditions, may indicate adaptive moral resilience—the ability to sustain or restore integrity under ethical pressure³⁸. Future interventions should aim to cultivate such resilience through ethics education, reflective supervision, and peer support mechanisms.

Conclusion

This study highlights that ethical dilemmas are an inherent and frequent component of nursing practice in Greek primary healthcare, emerging across a wide range of professional situations. The findings reveal a workforce that, while demonstrating strong ethical values and positive moral attitudes, often operates in an environment lacking structured institutional support and consistent ethics education.

Nurses encounter ethical challenges that test their professional integrity, particularly when resource constraints, hierarchical pressures, or policy gaps limit their capacity for ethically grounded action. Despite these challenges, the observed commitment to patient autonomy, informed consent, and transparency reflects the moral resilience of Greek nurses working within complex social and institutional settings.

The analysis further underscores the influence of education and workplace context on ethical competence. Higher educational attainment was associated with stronger ethical knowledge and attitudes, while nurses working in areas serving migrant or refugee populations exhibited greater ethical sensitivity—suggesting that exposure to ethically complex care environments can cultivate moral awareness and empathy.

However, the study also identifies systemic deficiencies: limited access to ethics consultation, absence of

formal Ethics Committees in primary care, and insufficient continuing education on applied ethics. Addressing these gaps requires coordinated action across educational, institutional, and policy levels.

Implications for Practice, Education, and Policy

This study provides empirical evidence that education and workplace context shape nurses' ethical capacities. The findings support several recommendations:

1. Integrate applied ethics modules into undergraduate and continuing nursing education, emphasizing case-based moral reasoning.
2. Establish Ethics Committees or consultation teams within primary care units to facilitate ethical decision-making and conflict resolution.
3. Develop professional reflection groups and peer mentoring schemes to strengthen moral resilience.
4. Include ethics indicators in quality assurance and accreditation processes for primary healthcare services.

At the policy level, incorporating structured ethics programs into national nursing frameworks could promote ethical competence as a measurable quality dimension of healthcare.

Limitations and Future Research

The cross-sectional design limits causal inference, and self-reported data may be influenced by social desirability bias. Furthermore, the study focused on public primary healthcare units, and findings may not generalize to private or hospital settings. Future research should employ mixed methods—combining quantitative surveys with qualitative interviews—to explore nurses' lived experiences of ethical conflict and the contextual mechanisms that foster or hinder ethical practice.

Despite these limitations, this study provides robust, regionally grounded evidence that can inform ethics education and institutional policy design in primary healthcare.

ΠΕΡΙΛΗΨΗ

Διαχείριση Ηθικών Εντάσεων στη Νοσηλευτική Πρωτοβάθμιας Φροντίδας Υγείας: Συχνότητα, Αντίκτυπος και Στρατηγικές Αντιμετώπισης Ηθικών Διλημάτων**Λάμπρος Θεοδοσόπουλος^{1,*}, Ευάγγελος Φραδέλος², Ασπασία Παναγιώτου³, Φωτεινή Τζαβέλλα⁴**¹Νοσηλεύτης, ΜΗScN, Υποψήφιος Διδάκτωρ, Τμήμα Νοσηλευτικής, Πανεπιστήμιο Πελοποννήσου, 22131 Τρίπολη, Ελλάδα²Αναπληρωτής Καθηγητής, Εργαστήριο Κλινικής Νοσηλευτικής, Τμήμα Νοσηλευτικής, Πανεπιστήμιο Θεσσαλίας, 41110 Λάρισα, Ελλάδα³Αναπληρώτρια Καθηγήτρια, Τμήμα Νοσηλευτικής, Πανεπιστήμιο Πελοποννήσου, 22131 Τρίπολη, Ελλάδα⁴Αναπληρώτρια Καθηγήτρια, Τμήμα Νοσηλευτικής, Πανεπιστήμιο Πελοποννήσου, 22131 Τρίπολη, Ελλάδα

Εισαγωγή: Η λήψη ηθικών αποφάσεων αποτελεί θεμελιώδη διάσταση της νοσηλευτικής πρακτικής. Ωστόσο, λίγα στοιχεία υπάρχουν για τη συχνότητα και τη φύση των ηθικών διλημάτων στην Πρωτοβάθμια Φροντίδα Υγείας (ΠΦΥ). Οι νοσηλευτές εργάζονται συχνά αυτόνομα, σε περιβάλλοντα με περιορισμένους πόρους και ανεπαρκείς θεσμικές δομές ηθικής υποστήριξης.

Σκοπός: Σκοπός της μελέτης ήταν η διερεύνηση της συχνότητας, του αντίκτυπου και των στρατηγικών διαχείρισης των ηθικών διλημάτων στους νοσηλευτές της ΠΦΥ στην Ελλάδα, καθώς και ο εντοπισμός δημογραφικών και επαγγελματικών παραγόντων που προβλέπουν τις ηθικές στάσεις και τις γνώσεις τους.

Υλικό και Μέθοδος: Πραγματοποιήθηκε συγχρονική, περιγραφική-αναλυτική έρευνα σε 492 νοσηλευτές που εργάζονται σε δομές της δημόσιας ΠΦΥ, στην περιοχή ευθύνης της 2ης Υγειονομικής Περιφέρειας Πειραιώς και Αιγαίου. Η συλλογή δεδομένων έγινε με ανώνυμο ερωτηματολόγιο, το οποίο περιελάμβανε δημογραφικά χαρακτηριστικά και το εργαλείο Nurses' Ethics Questionnaire (NEQ-Gr). Η ανάλυση πραγματοποιήθηκε με περιγραφική στατιστική, διμεταβλητές δοκιμασίες και πολυμεταβλητή γραμμική παλινδρόμηση (IBM SPSS Statistics 28.0).

Αποτελέσματα: Τα ηθικά διλήματα ήταν συχνά: το 73% των νοσηλευτών δήλωσαν ότι τα αντιμετωπίζουν τουλάχιστον μηνιαίως. Ηθική δυσφορία, δηλαδή ανάγκη ενεργειών αντίθετων με τις προσωπικές αξίες, ανέφερε το 47% του δείγματος. Η συνολική βαθμολογία ηθικών στάσεων ήταν υψηλή (ΜΟ $3,8 \pm 0,4$), με κυρίαρχες τις αξίες ειλικρίνειας, της συγκατάθεσης και της αυτονομίας του ασθενούς. Η ανώτερη εκπαίδευση ($b = 0,03$, $p = 0,048$) και η εργασία σε περιοχές με δομές φιλοξενίας προσφύγων ($b = 0,18$, $p < 0,001$) προέβλεψαν θετικότερες ηθικές στάσεις. Η εκπαιδευτική βαθμίδα ήταν ο μοναδικός στατιστικά σημαντικός προβλεπτικός παράγοντας για τις γνώσεις ηθικής ($b = 0,10$, $p = 0,014$).

Συμπεράσματα: Οι νοσηλευτές της ΠΦΥ στην Ελλάδα αντιμετωπίζουν συχνά πολύπλοκες ηθικές καταστάσεις, σε περιβάλλοντα με περιορισμένη θεσμική υποστήριξη. Η εκπαίδευση και το εργασιακό πλαίσιο επηρεάζουν ουσιαστικά την ηθική τους επάρκεια. Η ενίσχυση της εκπαίδευσης, η σύσταση Επιτροπών Δεοντολογίας και η καλλιέργεια ηθικής ανθεκτικότητας αποτελούν κρίσιμα βήματα για την υποστήριξη της ηθικής ακεραιότητας και της ποιοτικής φροντίδας στην ΠΦΥ.

Λέξεις-κλειδιά: Νοσηλευτική, Ηθική, ηθικά διλήματα, Πρωτοβάθμια Φροντίδα Υγείας, ηθική δυσφορία, ηθική γνώση, ηθικές στάσεις, Επιτροπές Δεοντολογίας

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